Background: Stent graft infection is a rare but serious complication in patients who underwent endovascular aortic aneurysm repair. Particularly removal of suprarenal fixing stent graft carries risk of aortic or renal artery injury. There have been reported several options of aortic reconstruction after successful removal of infected device.

Technical Description: 1. Exposure of aorta and proximal and distal control. 2. Removal of aortic stent graft with syringe technique which include preparation of syringe, exposure of stent graft, removal of stent graft. 3. Preparation of cyropreserved aortic and arterial allografts: thawing and rinsing of cryopreserved arterial allografts, composition of allografts to make bifurcated aortic graft. 4. In situ aortic reconsctruction: aorto-iliac reconstruction and graft omentum wrapping of the grafts.

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SS14.

Comparison of Covered Stents versus Bare Metal Stents for Treatment of Chronic Atherosclerotic Mesenteric Arterial Disease

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Objectives: To compare outcomes of mesenteric angioplasty and stenting (PTAS) using iCAST covered stents (C-PTAS; Atrium, Hudson, NH)) or bare metal stents (BM-PTAS) in patients with chronic mesenteric ischemia (CMI).

Methods: We reviewed the clinical data of 225 patients (65 male and 160 female; mean age 72±12 yrs) treated for CMI (2000-2010). Outcomes were analyzed in patients who had primary intervention or re-intervention using BM-PTAS (n=164 patients/ 197 vessels) or C-PTAS (n=61 patients/ 67 vessels). End-points were freedom from restenosis, recurrence and re-intervention, and primary and secondary patency rates.

Results: Patients in both groups had similar demographics, cardiovascular risk factors and extent of disease. Mean follow up was 27±12 months. Patients treated by C-PTS had less restenosis, recurrences and re-interventions compared to those treated by BM-PTAS, both in the primary intervention and in the re-intervention groups ($P<.05$); primary patency at 2-years was significantly higher for C-PTAS compared to BM-PTAS in the primary intervention group (91±6 vs 60±5; $P<.003$).

Conclusions: In this non-randomized study covered stents were associated with less restenosis, recurrences and re-interventions in patients undergoing primary interventions or re-interventions for CMI.

Table.

	Bare metal stents (n=164 pts/197 vessels) % ± SD[a]	*Covered stents (n=61 pts/ 67 vessels)*	P *value*
Primary intervention group	n=149 pts/181 vessels	n=42 pts/45 vessels	
Freedom from restenosis	53±4	92±6	.003
Freedom from recurrence	58±4	95±5	.001
Freedom from re-intervention	59±5	95±5	.001
Primary patency	60±5	91±6	.003
Secondary patency	95±2	100	.46
Reintervention group	n=15 pts/16 vessels	21 pts/22 vessels	
Freedom from restenosis	49±14	89±10	.04
Freedom from recurrence	44±14	89±10	.001
Freedom from re-intervention	56±12	89±10	.03
Primary patency	45±14	60±12	.08
Secondary patency	100	82±10	.10

[a]2-year Kaplan-Meier estimates

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SS15.

Progress in Management of Visceral Ischemia from Type B Dissections

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Objectives: Malperfusion syndrome is a known predictor of poor outcome in acute type B dissection. We describe our experience with endovascular revascularization in the acute setting.

Methods: Consecutive patients undergoing intervention for malperfusion or branch vessel ischemia presenting with acute type B dissection between 6/2003 and 3/2011 were reviewed. Details of the presenting condition, surgical intervention, and postoperative course were collected. Descriptive and inferential statistical analyses were planned including survival and freedom from reintervention analysis using a Cox proportional hazards model.

Results: A total of 61 patients were identified with malperfusion in at least one territory, including spinal cord in 7/61 (12%) mesenteric in 37/61 (61%), renal in 45/61 (73%) and lower extremity in 38/61 (62%). Thoracic stent grafts were placed in all patients, and 41% of patients required adjunctive branch vessel stenting. After intervention, resolution of the ischemia was reported in 57/61